

# Psychological ‘burnout’ in healthcare professionals: Updating our understanding, and not making it worse

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## Abstract

Many healthcare professionals and professional societies are demanding action to counter ‘burnout’, especially in the acute care medical specialties. This review is intended to empower this laudable ‘call to arms’, while also validating concerns that have been raised about how we typically define, measure and counter this important issue. This review aims to advance the discussion, dispel common misconceptions, add important nuance, and identify common ground. We also encourage the ideas contained within the military term ‘occupational stress injury’, which include a cultural shift away from blame and stigmatization, and towards shared responsibility and empathy. We also outline why mandatory testing can be troublesome and why interventions should be tailored to individuals. While the need for immediate action may seem self-evident, we wish to mitigate the real possibility that good intentions could make a perilous situation worse. ‘Burnout’ matters, but how individuals and organizations go forward matters even more.

## Keywords

Burnout, occupational stress, physician health, resilience, wellness

## Introduction

The term “burnout” was popularized in the 1960s following the novel “The Burnt-Out Case” by Graeme Greene.<sup>1</sup> In the 1970s and 1980s, the psychologists Herbert Freudenberger and Christine Maslach adopted this term to describe a wide-ranging burnout syndrome (BOS) that encompasses three key domains: emotional exhaustion, depersonalisation and loss of self-worth.<sup>2</sup> Five decades on, many healthcare professionals (HCPs) and professional societies are demanding action to counter burnout, especially in specialties such as Intensive Care and Anaesthesiology.<sup>3–6</sup> We wish to empower this laudable ‘call to arms’, and to assist HCPs and administrators. However, others have raised valid concerns that excessive attention to negative emotions could damage our profession’s reputation, discourage applicants, and spread despondency. This review aims to advance the discussion, add nuance, identify common ground, and encourage meaningful action. We also wish to mitigate the possibility that good intentions could make a perilous situation worse.

The need for action may seem self-evident. After all, HCPs are the most studied ‘burnout’ profession,

and high burnout scores (see below) are reported in one-third to one-half of doctors and nurses, especially in the acute care specialties.<sup>3,4</sup> There are also reports that suicide rates may be 2–3x higher in HCPs than the general population.<sup>7</sup> Employee wellness is important, and we applaud groups such as the Intensive Care Society for prioritizing the spectre of burnout. However, it is worth emphasizing that many HCPs find great meaning and enjoyment from their work. Moreover, as outlined below, there are valid concerns about whether HCPs should be routinely screened, whether BOS can be reliably diagnosed, and whether

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crude interventions help or harm.<sup>8</sup> There can also be stigma attached to labelling a doctor or nurse as ‘burnt out’.<sup>9–12</sup> This could include that person being isolated or shunned, or considered psychologically unstable. Accordingly, burnout labels have even been regarded as a form of bullying and discrimination, a way to silence dissent, and a method by which we hold people back (especially females).<sup>13</sup> In this way, unfair accusations can stall the promotion of novel role models and much needed change agents. Regardless, any associated reputational damage can take years to fix, and will not aid recovery.

While it is understandable that HCPs are eager for others to act, there is an important debate to be had about how much of the responsibility for burnout lies with the individual and how much is the responsibility of colleagues and institutions.<sup>9–13</sup> Similarly, there are doubts as to how much we can remove the innate stresses of healthcare, or change the personalities of those attracted to the job.<sup>14</sup> There is even concern that indiscriminate discussions about negative emotions can create a ‘burnout contagion’ (see below).<sup>15</sup> In short, burnout matters greatly; how we go forward matters even more.

### Common “burnout” misconceptions

Before addressing any perceived affliction, we need terminology that is widely acceptable, minimally stigmatising, and action-focused. After 50 years relying on a term co-opted from a written work of fiction, we question whether our understanding is entirely ‘fit for task’. The diagnosis of burnout, and its collective management, may be hampered by a term which was never designed for real-world concerns, nor for diagnostic precision, nor consensus.

It is worth emphasizing that:

1. What is typical understood as burnout is not guaranteed, terminal or static. This is despite using a term that, if taken literally, would suggest irreversibility. Instead, emotions can wax and wane, even within a single day. Moreover, some people will thrive, no matter what.
2. This chimeric condition is self-diagnosed, and fails to fully recognize that modern life – and not just working in healthcare – is stressful.
3. Symptoms differ amongst individuals, including within the three domains: emotional exhaustion, depersonalisation and loss of self-worth. Burnout may manifest as cynicism, anger, or meanness in some, and withdrawal and silence in others. It can also go undetected by individuals and those around them.
4. What is commonly understood as burnout can affect junior practitioners – not just those with years of exposure – especially if those HCPs have an imbalance between expectations and reality.
5. Burnout is not a binary or dichotomous condition. In other words, it is not merely present or

absent. Instead, burnout describes a lower emotional state on a continuum that incorporates the three aforementioned subdomains.

6. There is no score that indicates definite ‘burnout’ or ‘no burnout’. Instead, scoring helps identify *risk of burnout*. At best, scoring can be used to monitor emotional state over time, and can spur reflection.
7. Unlike other health afflictions (i.e. major depressive illness), there is no minimum symptom duration required.
8. Resilience – namely the ability to ‘bounce back’ – is one way to mitigate burnout (though we must guard against misusing the term resilience too). The burnout/resilience balance may matter more. In other words, burnout may manifest when coping strategies wane rather than when stress spikes.
9. Given the complexity of diagnosis, and the variety in presentation, it is unreasonable to expect a one-size fits all treatment, or specious phrases such as “just learn to say no when you feel stressed or under resourced”
10. Just as some people “bounce back” no matter what, some even “bounce forward.” What might cause one HCP to despair may help another to grow.

Because our understanding of burnout varies so widely, indiscriminate testing and crude treatment may not help and may harm. Regardless, after half a century, the term burnout appears to have morphed into an imprecise catch-all that can mean different things depending on one’s viewpoint.<sup>14,16</sup> The word burnout may also be used to describe conditions that range from workplace annoyance to suicidal depression; from dark humour to substance abuse; and from agitation to psychiatric disease. In short, the term burnout invites both under and over diagnosis. Provocatively, burnout is typically viewed as a negative inappropriate response. It may be entirely logical when one considers the stresses associated with working in healthcare. It may even be a necessary stimulus, or an inner voice, that encourages self-reflection and life change. If so then it should not be pathologized or chased away. Next comes the issue of quantifying burnout.

### How we screen for burnout

The Maslach Burnout Inventory (MBI) is the most commonly used screening test. Perhaps, we should not expect a one-dimensional test to encapsulate the myriad experiences of HCPs: especially one that takes less than 15 min and incorporates only 22 items. The test is also based on a 5-point Likert scale (ranging from strongly disagree to strongly agree), whereas emotions might just as randomly be summarized using a 2-point or 10-point scale.

Alternatively, it might be better to employ narrative sentences to capture complex emotions.

Regardless, burnout scores can be skewed by transient stress, by comorbid conditions, and by fatigue: whether physical, emotional or compassion fatigue.<sup>17,18</sup> There is also insufficient test-retest confidence, and the possibility of test-fatigue.<sup>18,19</sup> Notably, the MBI limits a-priori what will be included and quantified, and does not encourage HCPs to describe positive emotions. Accordingly, the MBI may be the best we currently have but is not robust enough to accurately quantify improvement or worsening over time. These handicaps mean it is similarly flawed in pinpointing whether interventions help or harm.

Rightly or wrongly, use of the MBI has been associated with a focus on the individual and how they subjectively feel. This contrasts with the broader macro or meso system level and the effect of triggers including – but not necessarily limited to – interpersonal relationships, organizational demands, leadership styles, job security, harassment or bullying, sexism, increasing bureaucratic demands and broader societal issues. The MBI also fails to fully consider the influence of factors such as staffing rotas, flexibility, finance recompense, legal risks, workload, practice latitude, shift work, workplace collegiality or lack thereof, control versus demands, and whether individuals regard stimuli as threats or opportunities.<sup>12–14</sup>

As outlined, we should not use the MBI to reach dichotomous conclusions.<sup>8,14</sup> Accordingly, we cannot confidently state HCPs are burned-out vs. non-burned out, a little or a lot burned-out, or appropriately versus inappropriately burned-out. While there are three BOS subdomains, there is a lack of consensus whether high scores are required in one, two or all three domains. There is no gold standard test for burnout, which in turn makes it difficult to talk about sensitivity and specificity. A high score in the subdomain of emotional exhaustion may simply reflect the busyness of modern life. There is also insufficient data to determine if BOS risk is associated with demographics such as profession, gender or age. In short, the MBI is a test that looks for burnout, and therefore presumably primes HCPs to assume that they are afflicted. This can become a self-fulfilling prophecy if HCPs look only for supportive evidence, and fail to understand the complexities of modern life and healthcare.

### Why not just test everybody?

HCPs understand that we rarely screen large populations unless we have tests that are sensitive and specific, coupled with therapies that are reliable and long lasting. The same should apply to burnout, which is why mandatory screening is not indicated. Ricou et al.<sup>8</sup> speculated that a major trigger for clinician burnout is excessive oversight, instruction and scrutiny. If so then further surveillance could increase the sense of ‘depersonalization’. Additional interference could increase perceived ‘exhaustion’, or further loss

of ‘meaning’ for those that abhor bureaucracy. Testing can increase the feeling that management is targeting functioning clinicians rather than dysfunctional organizations or ‘toxic workplaces’. Alternatively, if testing is not mandatory then we could expect low response rates, along with results that are inaccurate, irreproducible, and non-generalizable.

Any fear that test results will be used punitively – or minimized – could skew responses. If frontline HCPs do not trust the medical leadership or the organization then mandatory screening is unlikely to be welcomed. In contrast, a vicious cycle can occur if testing increases resentment or if interventions use flimsy data and faulty assumptions or if no effective interventions actually occur. This is why Ricou et al.<sup>8</sup> suggested implementing meaningful change in all units *before* screening. Alternatively, we may face a catch-22 where ‘good workplaces’ are ignored, and ‘bad workplaces’ feel vilified.

### We can make ‘burnout’ worse

The idea of ‘burnout contagion’,<sup>15</sup> namely that we can influence people such that they feel more or less burnout, is fascinating and cautionary. The idea of ‘burnout contagion’ may be unpopular with HCPs who fear it could be used to excuse backroom inaction, frontline blame and widespread stigmatization. Regardless, the concern is that emotions are ‘infectious’. This is especially valid in professions such as healthcare because practitioners are emotionally and socially attuned, and able to mirror others’ feelings. Provocatively, the contagion theory challenges whether burnout is solely done to HCPs, namely as the result of external pressures, i.e. excessive workload, unreasonable demands, or inadequate control. Instead, it adds the provocative idea that burnout is also caused or mitigated by HCPs, namely we share responsibility for an interpersonal social phenomenon spread between workers. If we accept that co-workers can inspire others, we should accept that we can spread despondency.

The idea of contagious emotions and ‘burnout-virus’ may explain why hearing complaints from colleagues is the most important predictor of high burnout scores in oneself.<sup>15</sup> There can be a feedback loop where indiscriminate complaining increases ‘burnout’s’ likelihood and intractability. Rather than being seen as a form of blame, the idea of ‘burnout contagion’ can be helpful. It could highlight infected workplaces in need of ‘emotional decontamination’, rather than deficient individuals in need of firing. Just as we do not blame workers if they catch the flu virus, we should not scold HCPs for feeling unfulfilled, emotionally exhausted, depersonalized or worthless. The flu analogy reminds us all to take precautions. It also emphasizes the importance of each member taking responsibility for the team’s health and resilience. We are not offering excuses for

inaction, but rather demanding more in-depth understanding, less blame and shared responsibility.

### Towards a better understanding

While much of the work on BOS has focused on healthcare, there has been much written about the psychological struggles of military personnel. Some may take umbrage at non-combatants using military language. However, there are parallels between HCPs reporting burnout and soldiers reporting post-traumatic stress disorder (PTSD).<sup>20</sup> Moreover, despite a tradition built on inner-toughness, the military have evolved its understanding, language and treatment in a way that Healthcare could emulate. What some currently call burnout overlaps with “secondary traumatic stress” and “vicarious trauma.” These terms also highlight the cumulative impact of managing difficult stressful situations, and the possibility that HCPs can re-live their experiences.<sup>19,20</sup>

The Canadian Military no longer officially uses the phrase PTSD. Instead, the umbrella term “Operational Stress Injury” (OSI) covers all psychological difficulty experienced by troops during and also following combat.<sup>21</sup> OSI deliberately encompasses a wider range of issues, offers a variety of responses, and is not solely for those on the frontline. Importantly, the military also offers help even after leaving the profession. OSI incorporates anger and social withdrawal, drug and alcohol problems, re-integration issues, suicidal ideation, PTSD, and depressive symptoms. Like burnout, it may be a catch-all term, but it is more medically focused and was coined in order to mitigate blame.

The term OSI originated because the term PTSD became stigmatized and because it did not fully capture the challenges being experienced by soldiers and their families. OSI was part of culture change and a way of allowing soldiers and families to understand their symptoms as an acquired condition, not a state of inadequacy. It was part of maturing beyond old ideas such as soldiers needing to “man up or move on,” or that the condition was irremediable. It also decreased legal action and financial compensation and popularized an image of the ‘wounded warrior’ and the ‘empathic leader’. It was also part of encouraging those who are struggling to accept that they are unlikely to heal without help. The ideas encompassed by OSI could be similarly useful for HCPs, especially if we wish to promote the idea that “to do well you must be well” and that “it is okay not to be okay.”<sup>14</sup>

### Towards a better state of mind

Obviously, changing terminology is no panacea, and actions matter far more than words. Moreover, it is worth emphasizing that terms such as burnout are likely outdated not simply because they are old, but

rather because they are associated with under or over diagnosis, under or over treatment, and stigmatizing labels.<sup>13</sup> To address medical OSI in a meaningful way, our approaches need to be tailored. In other words, we should mirror the push towards personalised medical. Vague terminology and crude interventions can mask significant illness. For example, some HCPs may require medication, work leave, a change in job, or even psychiatric care.<sup>9–14</sup> In contrast, if HCPs are merely experiencing fatigue – physical, emotional or compassion – then they can be offered minor interventions such as scheduled leave, career counselling, or social engagement.<sup>22</sup>

Overall, interventions need to be deliberate and bespoke. This includes sincere efforts to foster a supportive work environment, alongside attainable and finite performance expectations. Work schedules should pay attention not only to the number of hours/days/weeks but also to their timing. Periods of relative downtime should be encouraged and modelled. These efforts could make ‘work-life balance’ seem achievable, rather than an empty phrase, or, worst still, another area in which the HCP ‘fails to make the grade’.

Like the military,<sup>21</sup> we propose a broader understanding of work-related distress along with shared responsibility and increased empathy. A non-judgemental approach highlights that work comes with innate highs and lows, and that a stressful career is best sustained with insight, humility and effort.<sup>14</sup> Terms such as OSI may make it easier to accept that many of us will experience temporary ‘un-wellness’ or ‘disengagement’,<sup>21,22</sup> and that career success should be measured over a longer time horizon. A deeper understanding may also encourage us all to devote comparable efforts towards workforce health as we do to budgets, public approval, and accreditation. Step-one is to end the search for simple solutions to a complex problem. The term burnout has carried an unfair load for decades; like many of us it could use a rest.



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